Short-Term Disability Claim Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Insurance Claims Management
Mutual of Omaha Plaza Omaha, NE 68175 – 0001
Phone 800-877-5176 Fax 402-997-1865

Section 1 – Employee Statement (Answer all questions to avoid delay)

Current Employer's Name	Group ID Number	Job Title	Hours Worked Per Week
Blue Mountain Production Company	G0000ARAF	Lab Technician	40

Name: James Benny Jackson

Address	City	State	Zip
[redacted]	Ripley	MS	38663

(Area Code) Home Telephone Number	(Area Code) Cellular Telephone Number	Social Security Number
[redacted]	[redacted]	[redacted]

Date of Birth	Height	Weight	Dominant Hand:		Marital Status	
06/04/1953	6'2"	250	X Right ___ Left	☑ Male ☐ Female	___ Single ☑ Married	___ Widowed ___ Divorced

Date of Disability (1st Day Absent)	Date First Treated	Estimated return to work date
04/27/2015	04/27/2015	Not known

Nature of illness and when symptoms first appeared, or describe how and where accident occurred.
Chronic cough & shortness of breath.

Was the disability work related? ___ Yes X No Have you filed a Workers' Compensation claim? ___ Yes ___ No

Was disability related to a motor vehicle accident or is another third party liable? ___ Yes X No

Physician's Name: Micheal D. Wilons, MD

Other income you have filed for, are receiving, or are eligible for:

	Amount	Date Claim Filed	Date Benefits Began
Workers' Compensation	$ N/A		
State Disability	$		
Other	$		

Important Notice: If you are age 60 or over, please contact your employer within 31 days of disability to preserve your group life insurance conversion privileges

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee's Signature: J Benny Jackson Date 5-5-15

EXHIBIT 14 PENGAD 800-631-6989

Exhibit "14"

DFTS 000002

Authorization to Disclose Health Information to my Employer

I authorize Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to disclose health information about me to my employer, and to my employer's broker. I understand that my employer, and its broker, will use this information to monitor and manage the disability benefits program provided under my Group Disability policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing disability benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information that may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization is valid for 24 months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:

ATTN: Group Insurance Claims Management
Mutual of Omaha Insurance Company / United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001

Or

Fax: 402-997-1865

I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization.

James Benny Jackson, [redacted], Ripley, MS 38663
(Printed Name and Address)

(Signature) 5-5-15 (Date)

OR

If applicable: I am the legal representative of the person whose financial and health information is to be disclosed, and I am authorized to grant permission on behalf of that person.

Printed Name of Legal Representative _____

_____ _____
(Signature of Legal Representative) (Type of Legal Rep.)

_____
(Date)

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Authorization to Disclose Personal Information

Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information.

I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

Claimant/Patient Name: James Benny Jackson

I authorize personal information to be faxed or mailed to.

Fax: 402-997-1865

Group Insurance Claims Management
Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I understand that the personal information disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my claim for disability benefit plan reimbursement and that if I refuse to sign this authorization my claim for benefits may not be paid.

I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, such personal information may be re-disclosed without the protection of the federal privacy regulations.

I understand that this authorization will expire 24 months after the date signed.

I understand that I may revoke this authorization at any time by faxing or mailing a request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance using the contact information provided above. If I revoke this authorization, it will not affect any use or disclosure of personal information that occurred prior to the receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

Name(s) used for records (if different than the name below): _____
Signature of Claimant: [signature]
Date Signed: 5-5-15

If Applicable: I am the legal representative of the claimant and I am authorized to grant permission on behalf of the claimant.

Printed name of Legal Representative: _____
Signature of Legal Representative: _____
Type of Legal Representative: _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Section 2 - Employer's Statement (Answer all questions to avoid delay)

Company Name	Group ID Number	Master Policy Number
Blue Mountain Production Company	G0000ARAF	

Class No or Description | Division / Location No or Description

Address	City	State	Zip	Email Address
31 CR 827	Blue Mountain	MS	38663	rhonda.barnes@oildri.com

Employee's Name: James Benny Jackson

Weekly earnings as defined by the Plan: $285 00
(Please note: Benefits will be calculated based on premium received.)

Number of weekly hours worked: 40

Was disability caused by employment? ___ Yes X No

Has workers' compensation claim been filed? ___ Yes X No

Does the employee contribute toward the premium? ___ Yes X No

If yes, what percent is paid by the employee? _____ % Pre-tax ___ Post-tax ___?

Employee's payroll classification (circle one) ___ Exempt ___ Non-Exempt ___ Salaried X Hourly ___ Union ___ Non-Union ___ Other

How was the employee paid?

Is this employee eligible for salary continuation / sick leave? ___ Yes X No If yes, what is the weekly amount? $_____

When do benefits begin? End?

Date of Hire: 02/20/2000 | Date Covered Under This Plan: 4/20/2000

Does Mutual of Omaha cover the employee for group long-term disability? ___ Yes X No

Does United of Omaha Life Insurance Company cover the employee for group life? X Yes ___ No If so, please complete the following

Name of employee's beneficiary according to your records: Wanda Jackson Relationship to employee: Spouse

Important Notice: For employees age 60 or over, refer to the policy provisions regarding group life continuation and conversion rights.

Please contact employee's direct supervisor and then circle the strength demand below which best describes the employee's job:

Circle One	S – Sedentary	10 lbs. Maximum lifting, occasional lift/carry of small articles. Some occasional walking or standing may be required.
	L – Light	20 lbs. Maximum lifting with frequent lift/carry up to 10 lbs A job is light if less lifting is involved but significant walking/standing is done or if done mostly sitting but requires push/pull on arm or leg controls
	M – Medium	50 lbs. Maximum lifting with frequent lift/carry up to 25 lbs
	H – Heavy	100 lbs. Maximum lifting with frequent lift/carry up to 50 lbs
	V – Very Heavy	Over 100 lbs. Lifting with frequent lift/carry over 50 lbs.

Employee's Job Title Lab Technician | Last Day at Work 04/23/15

What was the employee's employment status on the first day absent? Active

Description of major job duties – Please attach job description

Packaging Job includes all duties for Lab Technician.

Has the employee returned to work? ___ Yes X No

a) If yes, when?

b) If not, what is the estimated return to work date?

Can the employee's job be modified? ___ Yes ___ No

Signature of Person Completing Claim Form: Rhonda Barnes

Title of Person Completing Claim Form: Human Resources Coordinator

Date Signed	(Area Code) Phone Number	(Area Code) Fax Number	Email Address
5/5/15	(662)685-4386 ext.5002	(662)685-4341/(662)837-3027	rhonda.barnes@oildri.com

Please notify us if the Employee returns to work after the submission of this form.

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Section 3 – Attending Physician's Statement (Answer all questions to avoid delay)

Employer Name	Group ID Number
Name of Patient (Last, First, MI) – Please Print: Jackson James Benny	Date of Birth: 6-4-53
Diagnoses: Post infection bronchospasm, bronchospastic airway disease	ICD-9 Code(s): 519.11 519.19
Symptoms: cough, congestion shortness of breath, wheeze	Date symptom first appeared: Dec. 2014

Initial date of treatment: 4-27-15 | Last date of treatment: April 2015 | Next date of treatment / office visit: 5/27/15

Is disability due to: ___ Accident / Injury ✓ Sickness | Is the disability work related? ✓ Yes ___ No

If applicable, list the surgical procedure(s) - Describe fully and provide dates if any.

If disability is due to Pregnancy, please provide the information below.

Date of Last Monthly Period	Expected Date of Delivery	Expected Type of Delivery ___ Vaginal ___ Cesarean Section
Actual Date of Delivery	Actual Type of Delivery ___ Vaginal ___ Cesarean Section	

If any of the following questions are answered "Yes," then please provide the information to the right of that question.

Was the patient treated in an Emergency Room? ___ Yes ✓ No	Date treated	Name of Hospital	Name of Physician
Did another physician treat the patient? ✓ Yes ___ No	Date treated: 4/27	Physician's Name and Address: Michael Wolfe MD, Memphis Lung Physicians Foundation, 6025 Walnut Grove Rd, MFC Bldg, Suite 50?, 38120	
Was the patient hospital confined? ___ Yes ___ No	Dates Confined in Hospital: From ______ To ______	Name of Hospital	
Did patient have outpatient surgery in a hospital or ambulatory surgical center? ___ Yes ___ No	Date of surgery	Name of Facility	

Functional Limitations – Abilities

Indicate frequency per day the listed activity can be performed. (n = never; o = occasional; c = constant)

Indicate longest single time durations each activity can be performed

Lifting	Carrying			
____ 1-5 lbs.	____ 1-5 lbs.	____ Sitting	____ Kneeling	____ R: Finger Dexterity
____ 6-10 lbs.	____ 6-10 lbs.	____ Total time on feet	____	____ L: Finger Dexterity
____ 11-25 lbs.	____ 11-25 lbs.	____ Standing	____ Inside	____ R: Below Shoulder (Reaching)
____ 26-50 lbs.	____ 26-50 lbs.	____ Walking	____	____ L: Below Shoulder (Reaching)
____ 51-100 lbs.	____ 51-100 lbs.	____ Bending	____ Outside	____ R: Above Shoulders (Reaching)
____ Over 100 lbs	____ Over 100 lbs	____ Squatting	____ Working with Others	____ L: Above Shoulders (Reaching)
		____ Stooping	____ Other (explain) ________	

Has persistent resp issue bronchospasm in work environment. Removing him from contact [illegible] has failed [illegible] the whole company

Please notify Us if the Employee returns to work after the submission of this form.

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Mental Limitations – Abilities

	Excellent	Good	Fair	Guarded
Judgment / decision making				
Deal with work stresses				
Function independently				
Concentration / Attention span				
Emotional liability				
Caring for self / family				

Estimate overall prognosis

The patient has been continuously disabled (unable to work) from _____ to _____

Is the patient able to work with job modifications? ___ Yes ___ No

The patient should be able to work ___ full-time / ___ part-time on _____ ,or a specific date is unavailable, in ___ 1 month, ✓ 1 to 3 months, ___ 3 to 6 months, or ___ Other (please specify)

Remarks and/or treatment plan

Return of illegible when returns to work, please could cause further time out of work environment

Name of the Attending Physician – Please Print	Specialty / Degree(s)	Tax Identification Number
Dr Mike Wilson	Pulmonary	
Address (No., Street, City, State, Zip)	**(Area Code) Telephone Number**	**(Area Code) Fax Number**
6025 Walnut Grove Memphis, TN 38120	901-767-5864	901-767-6591

If necessary, whom can we contact at the attending physician's office for additional information?

Name: (Area Code) Telephone Number:

Signature of the Attending Physician Date

Please notify us if the Employee returns to work after the submission of this form.

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DFTS 000007